BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: LOLA M. Claimant, vs. SAN GABRIEL POMONA REGIONAL CENTER, Service Agency.	OAH No. 2011020400

DECISION

This matter was heard by Julie Cabos-Owen, Administrative Law Judge with the Office of Administrative Hearings, on August 15, 2011, in Los Angeles, California. Lola M. (claimant) was represented by her mother, Barbara M., and County Social Worker Mertis Brown, her authorized representatives.[1] San Gabriel Pomona Regional Center (SGPRC or Service Agency) was represented by G. Daniela Martinez.

Oral and documentary evidence was received, and argument was heard. The record was closed, and the matter was submitted for decision on August 15, 2011.

ISSUE

Does Claimant suffer from autism which would entitle her to receive regional center services?

[1] Claimant's and her mother's initials are used, in lieu of their last names, to protect their privacy.

FACTUAL FINDINGS

1. Claimant is a 17-year-old female (born March 28, 1994). She claims to be eligible for regional center services based on a diagnosis of autism. (Testimony of Barbara M. and Mertis B.)

2. Claimant had previously resided with her mother in Los Angeles after her father died in 2007. However, a higher level of care was determined to be necessary when she presented a risk of harm to herself and others. She was placed in foster care after a voluntary case was opened with the Department of Children and Family Services (DCFS). Claimant currently lives at Rosemary's Residential Treatment Facility, a temporary group home in Pasadena. (Exhibits 3 and 7.)

3. Claimant met all developmental milestones at age appropriate times, except for toilet training. Her mother had no developmental concerns until after first grade, when she exhibited problems separating from her mother. She began refusing to go to school and would sometimes leave school and return home. (Exhibits 3 and 7.) When claimant was in fifth grade, the school initiated a meeting to develop an Individualized Education Program (IEP) and recommended placement in a special education day program. Claimant's parents disagreed with the placement and instead opted to home-school her from fifth to seventh grade. Claimant attended a Catholic school briefly in the eighth grade, and attended tenth grade in a special day class at a non-public school, Rosemary Children's Institute. (Exhibits 3 and 7.)

4. Claimant's school records included the following:

(a) A June 19, 2008 IEP noting that claimant "is a student who is eligible for services through the Department of Mental Health [by way of findings indicating] that [claimant] is in need of residential treatment." Her eligible disability was listed as "Emotional Disturbance." At that time, claimant had difficulty fully accessing general education curriculum due to anxiety and frustration caused by her emotional problems. She also demonstrated difficulty adjusting, poor peer relations, difficulty coping with her feelings, poor impulse control, angry outbursts, and severe aggressive behaviors against adults and peers.

(b) A November 4, 2009 IEP noted that claimant "is a talkative and inquisitive student who excels most when she can display her creativity and uniqueness. She can be a friendly person and enjoys having conversations with others about her interests. When in a positive mood, she is very cooperative and friendly." The 2009 IEP also noted:

> [Claimant] appears to function at an age-appropriate manner. She is capable of reading grade-level material without much issue. Lola struggles with spelling compound words and more challenging vocabulary, but does well with guidance/assistance.
> [¶] . . . [¶]

> [Claimant] is able to communicate her needs and wants in an age-appropriate manner. During conversations, [claimant] tends to go off on tangents and has difficulty staying on topic. Otherwise, this does not appear to be an area of concern at this time.
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> [¶] . . . [¶]
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> [Claimant] has an extensive history of hospitalizations, suicidal ideations, violence towards peer and staff, and severe psychiatric symptoms such as depression, cutting behavior and hospitalizations. Since being re-admitted to Rosemary's, [claimant] has had a difficult time adjusting to being back. She assaults staff on a weekly basis, and has had several instances of destroying property. [Claimant] can be very obsessive about using the computer; according to staff reports, when [claimant] was sent home to live with her mother, her mother allowed [claimant] to continuously use the computer for 72 hours without stopping. [Claimant] becomes aggressive and violent towards others if she is not given computer time when she wants. She has attempted several times to destroy the computers in the school so that 'no one else can use them.'
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> [¶] . . . [¶]
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> [Claimant] has issues concerning the use of the bathroom on time. She has urinated and defecated on herself in school on at least two occasions, and is constantly doing this in her group home. It appears to be a self-management issue, and group home staff is apparently attempting to address this with [claimant]. (Exhibit 2.)

5(a) . Since March 2008, Claimant has been hospitalized numerous times in response to her being considered a danger to herself and others. (Exhibit 7.)

5(b). These hospitalizations include one on January 30, 2009, due to suicidal and homicidal ideations and reported auditory hallucinations. At time of admission, claimant's observed eye contact was "poor to fair," her "affect was flat and inappropriate," and her mood was depressed and angry. However, she had no abnormalities in her speech with regards to rate, rhythm and volume. She was discharged on February 2, 2009, with a diagnosis of Psychotic Disorder, Not Otherwise Specified. (Exhibit 7.)

5(c). She was hospitalized again in March 2009, then placed at Rosemary's Residential Treatment Program, where she lived from April 2009 through August 2009. She returned home to her mother on August 28, 2009, but within 30 days, was brought back to Rosemary's after she threatened to kill herself with a knife and police were called. After returning to Rosemary's, her behavior deteriorated, and she was reportedly hospitalized approximately 16 times in a span of nine months. (Exhibit 7.)

5(d). Claimant was readmitted on September 4, 2010. The stated reason for admission was as follows:

> The patient was walking out of her room [at her group home] in underwear only, was throwing things at her roommate, required restraints, broke a window, and attempted to cut herself. Patient was agitated, irritable, angry, wanted to cut herself and run into traffic, requiring acute psychiatric hospitalization to prevent self-harm. . . . She has tried to kill herself by cutting herself in the past. (Exhibit 7.)

5(e). Claimant was discharged on September 7, 2010, with a final diagnosis of bipolar depression. (Exhibit 7.)

6(a). In June 2010, claimant underwent a psychological evaluation at the Child and Family Assessment Center of the Children's Institute, Inc., in Los Angeles.[2] (Exhibit 7.)

6(b). In obtaining claimant's developmental history, the evaluator determined that claimant reached most developmental milestones in an age-appropriate manner with the exception of toilet training. Claimant's mother described claimant as an affectionate and outgoing child. Claimant's mother denied observing claimant engaging in any stereotypic behavior in the form of rocking, echolalia, vocal ticks, toe-walking, head-banging and hand-flapping. She also denied claimant engaging in unusual play behavior such as sorting or lining up of toys. However, she did recall claimant licking poles and eating grass at school, apparently to gain attention. Claimant is fixated with the computer and playing virtual reality games. She will stay up until late at night and refuse to share computer time. Claimant is sensitive to noise, touch and certain textures. She is also adverse to change. (Exhibit 7.)

6(c). Claimant's aggressive behaviors reportedly intensified over time, especially after the death of her father in 2007. She also exhibited defiant and threatening behavior at the group home. Claimant is very non-compliant and typically refuses to respond to any request. When her mother attempts to set limits, claimant responds by becoming highly volatile, aggressive and threatening. She becomes violent and will hit, kick, throw things destroy property, yell and scream. She has hit and punched her mother many times when she was upset with her. Claimant has been suicidal in the past and engaged in self destructive behavior (cutting herself, threatening to kill herself with a knife, trying to drown herself in the bathtub). She has failed to maintain long-term friendships. Claimant has occasional daytime enuresis and poor hygiene. She has a family history of schizophrenia (brother and paternal uncle). (Exhibit 7.)

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[2] The signature page of the June 2010 Psychological Evaluation report was not included in the evidence submitted at the hearing. Consequently, the identity and credentials of the evaluator were not established by the evidence.

6(d). The evaluator made the following observations regarding claimant's mental status during the evaluation:

> When the examiner made her way to the waiting area in order to greet [claimant, she] looked up to reciprocate the examiner's salutation and extended a flaccid arm to shake. [Claimant] agreed to accompany the examiner to the assessment room and she exhibited no fear or protest, despite the fact that she had never met this examiner before. Once inside the assessment room, [claimant] displayed a desultory energy level. Her voice, while pressured, had a dispirited quality. [Claimant] seemed to listen as the examiner explained the limits of confidentiality. She remained quiet as the examiner talked, appearing somewhat sad and empty. Eye contact was fair. [Claimant] was rather easy to engage; however, she seemed to lack appropriate social and/or emotional reciprocity. Specifically, when the examiner smiled at [claimant] she did not smile back. When the examiner encouraged [claimant] or rewarded her with positive verbalizations, [claimant's] demeanor did not change. She remained rather indifferent, and flat.
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> Throughout the assessment, [claimant] remained highly motivated and exerted a good deal of effort on all of the various tasks required (excellent persistence). . . . Attention and concentration were commendable. Mood appeared depressed if not melancholy. Affect was flat and consistent with mood. Overall, [claimant's] behavior appeared drab, apathetic, and sluggish. She just seemed bland and indifferent. There was no evidence of oppositionalism, defiance or aggression. To the contrary, [claimant] was obliging, considerate and polite (calling the examiner "Miss," saying "please" and "Thank you" at appropriate times).
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> [¶] . . . [¶]
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> Despite [claimant's] commendable behavior and the good testing rapport, the examiner wants to point out that at the time of the assessment, [claimant] was being treated with psychopharmacological medication that undoubtedly had an impact (e.g., calmed her down, increased her focus, decreased her agitation, and the medication is likely to have masked several of her symptoms) on her ability to perform and this examiner's ability to obtain an accurate assessment of her true level of functioning. Also, [claimant] has had a history of inconsistent schooling, which can undoubtedly be implicated in at least the verbal scores. Consequently, the current scores should be interpreted cautiously, with the above in mind. (Exhibit 7.)

6(e). To assess claimant's cognitive functioning, the evaluator administered claimant the Wechsler Intelligence Scale for Children – Fourth Edition (WISC-IV). Claimant obtained Full Scale IQ score of 73, which is in the Borderline range of development. According to the evaluator, claimant's verbal comprehension abilities and non-verbal problem solving skills were also in the Borderline range at a score of 73 each; her working memory was at the upper end of the "low average" range, as indicated by her score of 88; and her visual information processing was in the "low average range" at 83. (Exhibit 7.)

6(f). The Childhood Autism Rating Scale (CARS), a behavioral rating scale used for identifying autism, was administered using the examiner's observations during the testing, in conjunction with reports obtained from claimant's mother. Claimant obtained a score of 36.5, which according to the evaluator placed her in the Mildly-Moderate Autistic range. In arriving at this score, the evaluator noted:

> She displays a severely abnormal emotional response to certain situations, and severely abnormal adaptation to change (if she is forced to transition, [claimant] will typically become extremely angry and/or uncooperative). She also has a moderately abnormal taste and touch response, a moderately abnormal activity level in that when she is not on medication, she is extremely hyperactive. [Claimant's] relationships are also poor, in that [claimant] has been unable to maintain friendships over time. (Exhibit 7.)

6(g). The evaluator summarized her findings and opinions as follows:

> [Claimant's] individual therapist referred [her] for a psychological evaluation in order to assess her current level of functioning, noting that [claimant] presents with significant behavior problems that include anger outbursts, defiance, aggressive and threatening behaviors, impulsivity, suicidal ideation, poor coping skills and low frustration tolerance. Despite a history of intensive therapeutic intervention, [claimant's] symptoms continue to pose considerable problems across all areas of her functioning and development, in that her acting out behavior interferes with her ability to function at home, at school, and in the world. [This evaluation was requested] in an effort to clarify diagnosis and to determine any additional services that may be needed to assist in [claimant's] treatment.
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> [¶] . . . [¶]
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> [I]t appears that, overall, [claimant's] pattern of performance during the present evaluation (variable skill development across all subtests of the WISC-IV, as well impairments in executive functioning), in conjunction with third-party reports citing problems with listening,

following through with directives, giving close attention to work, keeping hands to self, being intrusive, moving and fidgeting much of the time, restlessness, impulsiveness, hyperactivity, are consistent with the symptoms associated with [Attention Deficit Hyperactivity Disorder (ADHD)]. The level of these behaviors reported by others, coupled with test data pointing to deficits across domains assessing aspects of attention and related functions, highlights [claimant's] extreme attentional and impulse-related problems and warrant treatment in this area aimed at remediating this constellation of behaviors/symptoms. . . . Diagnostically, however, the examiner believes that [claimant's] ADHD-like symptoms are part of a larger, overarching condition, that being an [Autism Spectrum Disorder (ASD)] and so, no separate diagnosis is required.

Based on the results of this assessment . . . the examiner believes that there is ample evidence to suggest that [Claimant] is contending with numerous autistic-like symptoms consistent with a diagnosis of an Autistic Disorder. Specifically, [claimant] has a history of developmental delays (a.) although she spoke her first words at a reasonable age, her comprehension of language (both verbal and non-verbal communications) has reportedly been poor; she has difficulty understanding another person's perspective or point of view and so it is hard for [claimant] to pretend, joke or tolerate teasing; she also reportedly has an adverse reaction to certain sounds; (b.) although she is said to have walked at an early age, tests scores find [claimant's] motor skills to be quite delayed; c.) toilet training has never really been successfully achieved, as [claimant] reportedly continues to wet herself somewhat regularly). She is also currently displaying a wide constellation of symptoms often seen in children with ASD's (CARS = 36.5). These include: a lack of social or emotional reciprocity, a failure to relate to peers and make and maintain relationships, circumscribed interests (computer, Japanese anime), problems with attention, no history of engaging in symbolic or imaginative play, self-injurious behavior (cutting, multiple suicide threats and attempts), antisocial/oppositional behavior, extreme aggression, depression/anxiety (including impairment in emotion and behavior regulation), and most importantly, social immaturity ([claimant] has a limited ability to make and maintain friends because of her limited social skills and inability to read social cues). [Claimant] is also said to display certain sensory sensitivities in the form of not liking noise, not wanting to wear clothes because of the way they feel against her skin and having very particular eating habits (eating only one particular food type, or eating grass and licking poles). She also has a history of significant problems with transitions to the point where she reportedly has catastrophic reactions to change, regressive behavior (enuresis and

more recently, smearing feces) when angered, and problems with destructiveness and explosive tantrums. Similar to children with ASDs, [claimant's] thinking is very concrete.

On an emotional level, the examiner is very concerned that the extent to which [claimant] is able to express, modulate and contain her affect and related behavior is, by report, almost wholly dysregulated. . . . And while affective dysregulation is not uncommon in children with ASDs, the intensity and chronic nature of [claimant's] irritability (marked by extreme angry and aggressive outbursts) appears excessive in comparison to those typical of an ASD child, spurring concerns of a possible mood disorder (early-onset Bipolar Disorder. . . . Furthermore, [claimant] has a history of experiencing numerous depressive symptoms (sleep disturbance, suicide ideation, irritability, difficulty concentrating, interpersonal problems). . . . Indeed, [claimant's] history of symptoms is very consistent with that of a youth struggling from an early-onset condition of bipolar disorder.

[¶] . . . [¶]

Based on [claimant's] collective symptomatology and history, she also meets the DSM-IV criteria for Oppositional Defiant Disorder. . . (Exhibit 7.)[3]

6(h). The evaluator diagnosed claimant with Autistic Disorder; Bipolar Disorder, Mixed Episode, severe without psychotic features; Oppositional Defiant Disorder; Parent-child relational problem; and Borderline-Intellectual Functioning. (Exhibit 7.)

7. In November 2010, after referral to the regional center, claimant's then-current level of functioning was noted by the Intake Service Coordinator to include the following:

Motor Domain: [Claimant] ambulates independently and is reported to walk with a steady gait. She is reported to have full use of her hands and fingers. No significant gross or fine motor skills were reported.

Independent Living Domain/Self-Help: [Claimant] feeds herself neatly with utensils. She dresses herself independently including all fasteners and other details. She independently completes toileting activities but continues to have bladder accidents during the day and night. [Claimant] reports that she loves to cook. She reportedly needs

[3] "DSM-IV-TR" refers to the Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Text Revised, which is published by the American Psychiatric Association. The Administrative Law Judge takes official notice of the DSM-IV-TR as a highly respected and generally accepted tool for diagnosing mental and developmental disorders.

> prompting and supervision to compete simple household chores such as making her bed and washing dishes. She is reported to use money but has difficulty budgeting and saving her money. [Claimant] reports that she enjoys going on outings but mostly goes with accompaniment, usually her mother. [Claimant] reports that she is able to make purchases with assistance. She states that she typically orders the same meal (steak) when she eats out in a restaurant. [Claimant] does not drive.
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> Social Domain/Emotional Domain: [Claimant] presented at today's meeting as pleasant and cooperative. She showed good eye contact and was easily engaged in conversation. [Claimant] has a history of significant emotional and behavioral problems which have required medication management and psychiatric hospitalizations. She has a history of suicidal ideation and /or being a threat to others. Records indicate that she has a history of noncompliance, oppositionality, and aggressive behaviors towards her mother and staff. Socially, [claimant] has a difficult time making and maintaining friendships as she is typically teased or bullied by peers. [Claimant] is reported to have sudden mood swings.
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> Cognitive Domain: [Claimant] was able to give her full name, age, birth date, and grade upon request. She reportedly reads at grade level and enjoys writing stories. [Claimant] reports that her favorite subject in school is English and her least favorite subject is Math. It is reported that [Claimant] has an attention span between five and fifteen minutes. She reports that she is easily distracted.
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> Communication Domain: [Claimant] is able to carry on a simple to a more complex conversation. She uses a broad vocabulary and words are in appropriate contexts. [Claimant] is able to answer questions appropriately and can follow a combination of verbal instructions. [Claimant's] speech is clear and readily understandable. (Exhibit 3.)

8(a). On November 16, 2010, Rebecca Perez, Psy. D., licensed psychologist, conducted a psychological assessment of claimant. The assessment included a review of records, an interview with claimant and Deana Carr of Rosemary Children's Services, observations of claimant and administration of diagnostic tools for measuring adaptive skills and for ascertaining characteristics of Autism. (Exhibit 4.)

8(b). In the area of adaptive functioning, Dr. Perez administered the Vineland Adaptive Behavior Scales, Second Edition (VABS-II); claimant and Ms. Carr provided the responses necessary for the completion of this test. Claimant's VABS-II scores placed her in the moderately low adaptive level in the Communication (standard score 74) and Socialization (standard score 70) domains and in the low adaptive level in the Daily Living

Skills (standard score 69) domain. Dr. Perez noted that " Domain scores are negatively impacted by compliance." She also noted:

> In regard to receptive communication, [Claimant] is able to follow multi-step instructions with incentive. [Claimant] admits that it is hard to follow "if-then" instructions. She can sit and listen to a story for 15 minutes, if not distracted. . . . With expressive communication [claimant] can report basic information such as her full name, age, date of birth, mother's address and phone number. She is able to participate in conversation. She could give simple directions on how to make something. She is able to state short and long-term goals, but may need help with steps to accomplishing the goals. [Claimant] is having success at the Rosemary School. She completes her required work and has completed extra work to get caught up to grade level. She is able to use the computer to type emails and reports. She asks her teacher for help with editing. Her reading level is said to be at the 10th grade.
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> With daily living skills, [Claimant] is capable of hygiene but needs reminding. . . . [Claimant] has a history of enuresis that continues to occur. She will change her own bed sheets if she wets the bed. Mediations are given to her by staff. She is described as messy, but can be tidier with incentives. Lola is able to follow a recipe. She uses kitchen appliances, such as the stove and microwave. She enjoys cooking, but would rather not clean. She is involved in a workability program at school. She works one hour a day Monday through Friday as a janitor. She will sweep, vacuum, take out the trash, turn off the computer and do general cleaning. (Exhibit 4.)

8(c). The Autism Diagnostic Observation Schedule (ADOS), Module 4, was administered. Dr. Perez noted:

> Due to concerns with possible symptoms of autism, examiner conducted an interview, reviewed background information, observed [claimant] during free time, and administered the [ADOS], Module Four. The ADOS was completed via interview and interaction. A total score of 1 was attained with the ADOS which does not meet the minimum score required for consideration of autism or autism spectrum.
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> The following is a summary of information collected and observed regarding social skills, behavior patterns, interests and communication development. No significant concerns were reported until [claimant] was in elementary school. Records indicate [claimant] was on time with developmental milestones. She began receiving mental health services at the age of 8 or 9. During the current appointment,

> [Claimant] demonstrated social abilities. Examiner observed adequate good eye contact that was well meshed with interaction. She displayed a variety of emotions and facial expressions. [Claimant] shared that she has had friends in the past, but currently only has acquaintances at the treatment facility. . . . However, she also spoke of being kind to her roommate. [Claimant] is reported to be doing a good job reporting her concerns to staff. However, once an incident has begun she has difficulty expressing her feelings. She is able to participate in sports activities at school. [Claimant] also participates in off-campus outings, but sometimes has difficulties when many girls are involved. [Claimant] shared feelings about her family, especially how much she misses her father. She spoke briefly about her brother in prison. [Claimant] shared that she plans to return home to her mother someday.
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> No repetitive behavior was observed. Review of records indicates no history of repetitive behavior. [Claimant] expressed a variety of hobbies and interests. She enjoys cooking, writing, drawing, listening to music. Her interests seem age-appropriate, for example she likes to listen to the music of Lady Gaga.
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> [Claimant] communicated in coherent sentences. She engaged in conversation easily and spontaneously shared personal information. She asked appropriate questions of examiner. [Claimant] was often talkative and animated. She volunteered a creative story. No unusual quality was noticed in her voice or rhythm of speech. She spontaneously used gesture with speech. (Exhibit 4.)

8(d). In her summary, Dr. Perez noted that claimant attained her developmental milestones on time, that she had a family history of schizophrenia, that she had numerous psychiatric hospitalizations, that she had a diagnosis of Bipolar Disorder, and that she was receiving special education services on the basis of "Emotional Disturbance." Dr. Perez also noted:

> Cognitive testing was not performed at this assessment as the [WISC-IV] was recently administered during the . . . assessment in June 2010. [Claimant] earned composite scores in the low average and borderline range.
>
> Adaptive skills were assessed via interview. Communication and Socialization domains were found to be in the moderately low range. The Daily Living Skills domain was in the mild deficit range. [Claimant] is suspected to be capable of higher adaptive abilities, but has issues with compliance.

> [Claimant] was assessed for symptoms of autism. She does not present with symptoms meeting criteria for the diagnosis of Autistic Disorder as she does not exhibit "qualitative impairment in social interaction." "qualitative impairments in communication," or "restricted repetitive and stereotyped patterns of behavior, interests and activities" as described in the DSM-IV-TR. A history of symptoms consistent with Oppositional Defiant Disorder and Bipolar Disorder have been documented. (Exhibit 4.)

8(e). Dr. Perez's diagnostic impressions were:

> [Claimant] continues to show symptoms of Oppositional Defiant Disorder and Bipolar Disorder. She does not exhibit symptoms consistent with Autistic Disorder. Her intellectual skills are above the range of Mental Retardation. (Exhibit 4.)

9. On January 21, 2011, SGPRC sent a letter to claimant's mother, informing her that they had determined claimant was not eligible for regional center services. Claimant's mother filed a Fair Hearing Request appealing that determination. (Exhibit 5.)

10. No expert testimony was offered at the fair hearing. The parties relied solely on the records and the evaluation reports of Dr. Perez and the unidentified evaluator (See Factual Findings 6 and 8). Given that identity and credentials of evaluator were not disclosed by the evidence, his/her written opinions are not reliable. Additionally, the un-identified evaluator indicated that claimant had "autistic-like" symptoms which were consistent with a diagnosis of "an Autistic Disorder," and also compared claimant's symptoms to "children with ASDs." However, it was unclear from his/her report whether the evaluator was considering only Autistic Disorder or any other diagnoses along the autistic spectrum (i.e. Asperger's Disorder; Pervasive Developmental Disorder, Not Otherwise Specified, etc.). Furthermore, the unknown evaluator did not identify which of the specific criteria in the DSM-IV claimant purportedly met in order to arrive at a diagnosis of Autistic Disorder. Moreover, some information relied on by the evaluator was not corroborated by any of the other evidence (e.g. the evaluator noted that claimant's motor skills were "quite delayed," but that was not documented in any of the other reports in evidence.) Given the foregoing, Dr. Perez's opinions were more persuasive than those of the unidentified evaluator.

11. The evidence presented at the fair hearing failed to establish that claimant suffers from Autistic Disorder.

LEGAL CONCLUSIONS

1. Claimant did not establish that she suffers from a developmental disability entitling her to Regional Center services. (Factual Findings 1 through 11.)

2. Throughout the applicable statutes and regulations (Welf. & Inst. Code §§ 4700 - 4716, and Cal. Code Regs., tit. 17, §§ 50900 - 50964), the state level fair hearing is referred to as an appeal of the Service Agency's decision. Where a claimant seeks to establish her eligibility for services, the burden is on the appealing claimant to demonstrate that the Service Agency's decision is incorrect. Claimant has not met her burden of proof in this case.

3. In order to be eligible for regional center services, a claimant must have a qualifying developmental disability. As applicable to this case, Welfare and Institutions Code section 4512 defines "developmental disability" as:

> [A] disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual, and includes mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

4. To prove the existence of a developmental disability within the meaning of Welfare and Institutions Code section 4512, a claimant must show that she has a "substantial disability." In assessing what constitutes a "substantial disability" within the meaning of section 4512, the following provisions are helpful:

> California Code of Regulations, title 17, section 54001 states, in pertinent part:
>
> (a) "Substantial disability" means:
> (1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and
> (2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:
> (A) Receptive and expressive language;
> (B) Learning;
> (C) Self-care;
> (D) Mobility;
> (E) Self-direction;
> (F) Capacity for independent living;
> (G) Economic self-sufficiency.

In California Code of Regulations, title 17, section 54002, the term "cognitive" is defined as:

> [T]he ability of an individual to solve problems with insight, to adapt to new situations, to think abstractly, and to profit from experience.

5. In addition to proving a "substantial disability," a claimant must show that her disability fits into one of the five categories of eligibility set forth in Welfare and Institutions Code section 4512. The first four categories are specified as: mental retardation, epilepsy, autism and cerebral palsy. The fifth and last category of eligibility is listed as "disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation." (Welf. & Inst. Code, § 4512.) This category is not further defined by statute or regulation.

6. In order to establish eligibility, a claimant's substantial disability must not be solely caused by an excluded condition. The statutory and regulatory definitions of "developmental disability" (Welf. & Inst. Code, § 4512 and Cal. Code. Regs., tit. 17, § 54000) exclude conditions that are *solely* physical in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are *solely* psychiatric disorders or *solely* learning disabilities. Therefore, a person with a "dual diagnosis," that is, a developmental disability coupled with a psychiatric disorder, a physical disorder, or a learning disability, could still be eligible for services. However, someone whose conditions originate from just the excluded categories (psychiatric disorder, physical disorder, or learning disability, alone or in some combination), and who does *not* have a developmental disability would not be eligible.

7. In this case, claimant alleges that she is eligible for regional center services under the qualifying disability of autism. However, claimant has not established that she suffers from autism as defined by the DSM-IV-TR.

8. The DSM-IV-TR discusses Autism in the section entitled "Pervasive Developmental Disorders." (DSM-IV-TR, pp. 69 - 84.) The five "Pervasive Developmental Disorders" identified in the DSM-IV-TR are Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and PDD-NOS. According to the DSM-IV-TR, "Autistic Disorder must be differentiated from other Pervasive Developmental Disorders." (DSM-IV-TR, p. 74.) The DSM-IV- TR, section 299.00 states:

> The essential features of Autistic Disorder are the presence of markedly abnormal or impaired development in social interaction and communication and markedly restricted repertoire of activity and interests. Manifestations of the disorder vary greatly depending on the developmental level and chronological age of the individual. Autistic Disorder is sometimes referred to as *early infantile autism, childhood autism,* or *Kanner's autism*. (Emphasis in original.)

(*Id*. at p. 70.)

9. The DSM-IV-TR lists criteria which must be met to provide a specific diagnosis of an Autistic Disorder, as follows:

A. A total of six (or more) items from (1), (2) and (3), with at least two from (1), and one each from (2) and (3):

(1) qualitative impairment in social interaction, as manifested by at least two of the following:

(a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction

(b) failure to develop peer relationships appropriate to developmental level

(c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)

(d) lack of social or emotional reciprocity

(2) qualitative impairments in communication as manifested by at least one of the following:

(a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gestures or mime)

(b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others

(c) stereotyped and repetitive use of language or idiosyncratic language

(d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

(3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.

(b) apparently inflexible adherence to specific, nonfunctional routines or rituals.

(c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)

(d) persistent preoccupation with parts of objects

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in communication, or (3) symbolic or imaginative play.

C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.

(*Id*. at p. 75.)

10. In this case, since the credentials of the unidentified evaluator are unknown, there was no evidence that any psychologist diagnosed claimant with Autistic Disorder. Furthermore, Dr. Perez, a licensed psychologist who was found to be the more credible expert (see Factual Finding 10), specifically ruled out Autistic Disorder. According to the DSM-IV-TR, specific clinical criteria must be evident to diagnose Autistic Disorder. While Claimant does manifest some varying social and communication impairment, the evidence did not establish that she presented with symptoms meeting DSM-IV-TR criteria for the diagnosis of Autistic Disorder. As pointed out by Dr. Perez, claimant does not exhibit "qualitative impairment in social interaction." "qualitative impairments in communication," or "restricted repetitive and stereotyped patterns of behavior, interests and activities" as described in the DSM-IV-TR. Instead, she had a history of symptoms consistent with Oppositional Defiant Disorder and Bipolar Disorder, as was also noted in the unidentified evaluator's report. Consequently, Claimant has not established that she is eligible for regional center services under the diagnosis of autism.

11. The weight of the evidence did not support a finding that claimant is eligible to receive regional center services.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Claimant's appeal of the Service Agency's determination that she is not eligible for regional center services is denied.

NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.

DATED: August 30, 2011

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JULIE CABOS-OWEN
Administrative Law Judge
Office of Administrative Hearings